Basic Plan
Certificate of Coverage

for

STATE OF COLORADO

Employee Benefits Department of Personnel

DeltaPreferred Option (DPO) Dental Plan
a Preferred Provider Organization (PPO)

GROUP NUMBER - 6784

Delta Dental Plan of Colorado

INTRODUCTION

YOUR DENTAL PROGRAM

We are pleased to introduce you to your new dental program. This Dental Program, if used properly, will provide you one of the finest dental plans available anywhere. It is very important that you read this entire booklet to fully understand your benefits.

DEFINITIONS SECTION

DEFINITIONS

This section defines certain words as they are used by the companies that administer your coverage. Reading this section will help you understand your benefits as defined within the Certificate of Coverage (COC).

Administering Company - An organization that administers the Plan.

Benefit Year - Each Covered Person's **first** Benefit Year starts on the person's effective date and ends on the following December 31. After the Covered Person's first Benefit Year, all following Benefit Years start on January 1 and end on the following December 31. For example, if your coverage started on May 1, 2001, your first Benefit Year is May 1 through December 31, 2001. Your next Benefit Year is January 1, 2002 through December 31, 2002.

Certificate of Coverage - The document for the Plan that explains the benefits, limitations, exclusions, terms and conditions of your coverage.

Class I Services - Diagnostic, Preventive and Adjunctive dentistry.

Class II Services - Basic dentistry.

Class III Services - Major dentistry.

Class IV Services - Orthodontic dentistry. (Not a Benefit of Basic Plan)

COBRA - Consolidated Omnibus Budget Reconciliation Act.

Coinsurance - A percentage that a Covered Person pays for Covered Services after his or her Deductible is met.

Covered Person - The Employee and any of the Employee's Eligible Dependents who are enrolled under the Plan. "You" and "your" refer to the Covered Person.

Covered Services - The services that have been determined to be benefits under the terms and conditions of the Group Master Contract.

Deductible - The amount a Covered Person must pay each Benefit Year before a Plan pays for Covered Services.

Delta Dental Plan of Colorado (Delta) - Colorado Dental Service Inc., d.b.a. Delta Dental Plan of Colorado, herein called "Delta" is a nonprofit health care service corporation licensed in the state of Colorado. Delta is currently the Administering Company for the Plan.

DeltaPremier Participating Dentist - A DeltaPremier Participating Dentist means a Dentist who is licensed to practice and has executed an agreement with Delta to become a participating Dentist. DeltaPremier Participating Dentists agree to file a confidential listing of their Usual and Customary (UC) fees with Delta for approval. The DeltaPremier Participating Dentist agrees not to charge you over and above the Usual and Customary (UC) fees pre-filed with and approved by Delta.

DeltaPreferred Option (DPO) Dentist - A DeltaPreferred Option (DPO) Dentist means a Dentist who is licensed to practice, has met the criteria for the DeltaPreferred Option program and has made a special agreement with Delta to participate in that program. DeltaPreferred Option (DPO) Dentists have an agreement with Delta to accept the DPO Discounted Fee Schedule.

Dentist - A person duly licensed to practice dentistry by the government authority having jurisdiction over the licensing and practice of dentistry in the locality where the service is rendered as a Doctor of Medical Dentistry (DMD) or a Doctor of Dental Surgery (DDS). A Dentist is a person recognized by Delta to provide dental care for Covered Persons. Dentists may have agreements with Delta. The agreement a Dentist has with Delta affects the level of benefits you receive. Your Coinsurance and Deductible amounts depend on whether the Dentist you choose is In-Network or Out-of-Network.

DPO Discounted Fee Schedule - This schedule represents the highest amount on which Delta will base reimbursement for a Covered Service. The DPO Discounted Fee Schedule is determined by Delta. This schedule determines the maximum amount that a DeltaPreferred Option (DPO) Dentist can charge for a Covered Service.

Effective Date - The date the Employee or an Eligible Dependent is enrolled on the Plan's membership records for this coverage. This date is designated and provided to the Administering Company by your Employer.

Eligible Dependent - Any member of an enrolled Employee's family, including a legal spouse, who is eligible to enroll under the Employee's coverage. The dependent must meet the eligibility requirements defined in Enrollment of Dependents under the General Section.

Emergency Services - Dental services which are required for alleviation of severe pain or for immediate diagnosis and treatment of unforeseen conditions which, if not immediately diagnosed and treated, would lead to serious impairment of the patient's health.

Employee - "Employee" is defined by the Colorado Revised Statutes (CRS), sections 24-50-601 through 615.

Employer - The State of Colorado, acting through the Department of Personnel, or its designee.

Extended Coverage (Extension of Benefits) - Upon termination from the Plan, specific dental services may be considered for continued benefits as described under the General Section.

Group - The State of Colorado.

Group Master Contract - The contract between the State of Colorado and the Administering Company. These contracts contain the procedures for administering your Plan and detailed criteria for eligibility of benefits.

In-Network Coverage - The level of coverage that gives you the highest benefit level at the lowest out-of-pocket expense to you. To receive In-Network Coverage you must:

- receive services from a DeltaPreferred Option (DPO) Dentist.

Member - Subscriber (enrolled employee) and your eligible enrolled dependents.

Non-Participating Dentist - A Dentist who has not made any agreements with Delta to limit charges for Covered Services or to bill Delta directly. If you use a Non-Participating Dentist, **you pay** the Dentist's full billed charges and Delta will reimburse **you** according to the DPO Discounted Fee Schedule. Any difference in costs between the Dentist's full billed charges and the amount paid to you by Delta is **your** responsibility.

Open Enrollment - A period of time provided once each year when Employees and Eligible Dependents may enroll in the State of Colorado's Dental Plan. Anyone who enrolls in the Plan during Open Enrollment will receive benefits, starting in January of the following year, under the dental Plan.

Out-of-Network Coverage - Out-of-Network Coverage is the level of benefit you receive when:

- you receive services from a DeltaPremier Participating Dentist, or
- you receive services from a Non-Participating Dentist.

Out-of-pocket expenses are generally higher for Out-of-Network Coverage.

Plan - The Administering Company determines the benefits, limitations, exclusions and payments for the Plan. The final interpretation of any information in the Certificate of Coverage is governed by the Plan's Group Master Contract.

Policy Year (Calendar Year) - A period of twelve (12) consecutive months during which the terms of the Group Policy are in force.

Preauthorization - Advance written estimate of benefits received from Delta.

Subscriber - The Subscriber is the person whose employment or other status (except Eligible Dependent status) is the basis for enrollment eligibility.

Usual and Customary (UC) - For the purposes of this Plan only, the words "Usual and Customary (UC)" refer to a DeltaPremier Participating Dentist's confidential fee listing that is submitted and approved according to an agreement made with Delta.

GENERAL SECTION

ELIGIBILITY

An eligible employee is a person employed by the State of Colorado who meets the definition of employee as defined by Colorado Revised Statutes (CRS) 24-50-601 through 615. Temporary workers are not eligible.

ENROLLMENT OF DEPENDENTS

An eligible dependent is a dependent of the eligible employee who is qualified for coverage. Eligible dependents may include:

- A legal spouse. If the spouse is common-law, a signed common-law affidavit is required as proof. An affidavit form is included in your enrollment packet.
- An unmarried child, through the end of the calendar year in which the child becomes age 19.
- A child of the employee who is a full-time student and is dependent on the employee for support and maintenance. Proof of full-time student enrollment in an educational or vocational school is required. The student is eligible until:
  - the end of the calendar year in which he or she is no longer a full-time student, or
  - the end of the month in which he or she becomes age 24, even if they remain a full-time student.

ENROLLMENT OF DEPENDENTS (Cont.)

- An unmarried child who is incapable of self-support because of mental incompetence or severe physical handicap. A child, of any age, may be covered if medically certified as disabled and dependent upon the parent regardless of when disability occurred.
- An unmarried child for whom the employee must provide coverage because of a court order. The child may be covered through the end of the calendar year in which the child becomes age nineteen (19), or through the end of the month in which the child becomes age twenty-four (24), if he or she is a full-time student. A copy of the court order is required.
- No one may be covered as a dependent and also as an employee, and if both parents are covered as employees, children may be covered as dependents of one employee only.
- Dependents in active military service are not covered.

The word "child" means the employee's:

- natural child
- child placed for adoption before the adoption is legally finalized
- legally adopted child (as defined by the Group)
- stepchild
- foster child
- grandchild of covered eligible parent (with appropriate legal documentation of dependency)

The child must depend on the employee for at least one-half of his or her support in a normal parent-child relationship, except in the case of court-ordered coverage.

You must contact your agency payroll/personnel administrator to add, change, or delete a dependent. It is your responsibility to delete a dependent who is ineligible because of age within thirty-one (31) days.

EFFECTIVE DATE OF COVERAGE

You and your eligible dependents are eligible to enroll for coverage on your date of employment if you meet the State's actively-at-work requirements. Coverage under your plan normally begins on the first of the month following the first payroll deduction.

WHAT IS OPEN ENROLLMENT?

Employees and eligible dependents who are not enrolled may complete a Medical, Dental, Pretax Premium, Change Form to enroll during Open Enrollment. Your agency payroll/personnel administrator will notify you of Open Enrollment. You may also contact your agency administrator at any time for Open Enrollment information. Anyone who enrolls during Open Enrollment and has the applicable payroll deduction will have an Effective Date of January 1 of the upcoming year.

COVERAGE FOR DEPENDENTS UNDER AGE 5

Dependents under age five (5) are covered at no premium cost to the employee. During the month dependent(s) reach the age of five (5), the employee must complete a Medical, Dental, Pretax Premium, Change Form to add the dependent(s) and authorize the agency payroll/personnel administrator to change the deduction (if applicable).

HOW DO I REMOVE A DEPENDENT?

To remove a dependent from coverage, *you must*, within 31 days after the dependent becomes ineligible:

- fill out a Medical, Dental, Pretax Premium, Change Form available from your agency payroll/personnel administrator; and
- return the completed form to your agency payroll/personnel administrator.

HOW DO I REMOVE A DEPENDENT? (Cont.)

You must notify your agency payroll/personnel administrator of any changes that may affect your eligibility or your Eligible Dependent's eligibility (e.g., Employee's divorce, dependents emancipation or marriage, or dependent's reaching the maximum eligible age) within 31 days of the change. If you do not remove an ineligible Dependent within that 31 days, Delta reserves the right to recoup any benefit payments made for that person.

Your employer will ***never*** refund any more than two months of premiums which were paid for the ineligible dependent. In addition, your employer will not refund any premiums if Delta has paid any claims for the ineligible dependent which have not been recouped.

WHAT HAPPENS IF I DO NOT ENROLL WITHIN 31 DAYS?

If you or your eligible dependents do not enroll within thirty-one (31) calendar days of first becoming eligible, you ***cannot*** enroll until the employer's next Open Enrollment. For more information, please refer to P-11-13 under Chapter 11 of the ***State Personnel Director's Administrative Procedures***, published in the Colorado Code of Regulations (CCR).

TERMINATION OF COVERAGE

This coverage ends for any covered person, including eligible dependents, on the earliest of the following dates:

- The last day of the month that coincides with the employee's termination or reduction in hours.
- The date of the employee's death.

Note: Surviving eligible dependents are covered through the end of the month following the last payroll deduction of the deceased employee; after which surviving eligible dependents have the right to select COBRA continuation coverage.

- The date a covered person enters full-time duty in the armed forces of any country.
- The date the employee does not make a premium payment from the employer on time, when the employee's premiums are paid other than through payroll deduction, subject to applicable law.
- The date of misrepresentation or improper use of the Group Master Contract, Certification of Coverage, or Identification Card, improper claims filing, or false or incomplete information on the benefit enrollment/ membership change form. The Plan may recover any payments made because of improper actions.

Note: If you are age 65 or older and working, or you have a spouse, any age, who works, you may continue coverage on the same basis as people under age 65. Your rights to continue coverage may also be different if you are disabled or have end-stage renal disease. Please check with Medicare and Medicare coverage rules.

- The end of the month following the date on which a covered person no longer meets the eligibility requirements of the Group Master Contract.
- The date coverage ends under the Group Master Contract.
- The end of the month following the date on which the employee no longer meets the definition of employee under Colorado Revised Statutes (CRS) 24-50-601 through 615.

Coverage Ends for Eligible Dependents at the end of the month:

- in which the eligible dependent child marries.
- following the last payroll deduction by the Member for an eligible dependent(s) coverage.
- an eligible dependent no longer meets the definition of an eligible dependent.
- of your final divorce decree or legal separation from an eligible employee.
- when Member notifies the agency payroll/personnel administrator in writing to end an eligible dependent's coverage.

Coverage also ends for the eligible dependent at:

- the end of the calendar year in which he or she reaches age nineteen (19); or
- the end of the month in which he or she becomes age twenty-four (24), even if they remain a full-time student.
- the end of the calendar year in which he or she is no longer a full-time student.

BENEFITS AND COVERAGE

How to Use the DeltaPreferred Option (DPO) Dental Plan

DeltaPreferred Option (DPO) is the name of the Preferred Provider Organization (PPO) offered by Delta. There are three choice levels of Dentists:

1. In-Network DPO Dentists;
2. Out-of-Network DeltaPremier Participating Dentists; and
3. Out-of-Network Non-Participating Dentists.

You do not have to select a particular Dentist to receive dental benefits. Since there are no restrictions on which Dentist you may select, you have the freedom of choice. However, using the In-Network DPO provides for lesser "out-of-pocket" costs.

How the Discount Fee Schedule Works

All In- and Out-of-Network Dentists are paid according to the DeltaPreferred Option (DPO) Discounted Fee Schedule. This schedule determines the maximum amount of Delta's reimbursements for Covered Services. Out-of-network Dentists generally charge more for a particular service. Therefore, you are responsible for the difference in the Coinsurance up to Usual and Customary (UC) for DeltaPremier Participating Dentists, or the full billed charges for non-participating Out-of-Network Dentists.

DeltaPreferred Option (DPO) Dentists
(In-Network)

Delta DPO Dentists have agreed to accept the DPO Discounted Fee Schedule. If you or your Eligible Dependents live in an area where an In-Network DPO Dentist is not available, you must drive to an In-Network Dentist to receive this higher level of benefits.

- Dentist agrees to DPO Discounted Fee Schedule. You are responsible for Coinsurance and Deductibles.
- Dentist will submit claim to Delta.
- Dentist will charge you ONLY the Coinsurance and Deductible on the day services are performed.

DeltaPremier Participating Dentists (Out-of-Network)
DeltaPremier Participating Dentists have signed contractual agreements with Delta and have agreed to accept Delta's portion of the payment which will be paid according to the DPO Discounted Fee Schedule. In turn, DeltaPremier Dentists have filed a confidential listing of their Usual and Customary (UC) fees with Delta. After a DPO Discounted Fee payment is received by the Dentist from Delta, the DeltaPremier Dentist agrees not to charge you over and above the Usual and Customary Fees pre-filed with and approved by Delta.

- Dentist payment is based on DPO Discounted Fee Schedule. Dentist can charge difference in DPO payment up to Usual and Customary (UC) fees pre-approved by Delta. Dentist is LIMITED to UC fees approved by Delta.
- Dentist will submit claim to Delta. Delta will pay the Dentist and send you an Explanation of Benefits indicating the amount you are responsible for paying.
- Dentist may charge Coinsurance and Deductible on the day services are performed.

Non-Participating Dentists (Out-of-Network)
Non-Participating Dentists **have no agreements** and have not filed usual and customary fee listings with Delta. Therefore, if you choose a Non-Participating Dentist, you must pay the Dentist the full billed charges and Delta will reimburse **you** according to their DPO Discounted Fee Schedule. Any difference in costs between the Dentist's full billed charges and the amount paid to you by Delta is your responsibility.

- Payment to **you** is based on the DPO Discounted Fee Schedule. The Dentist can charge ANY amount above the DPO Discounted Fee payment. You are responsible for any difference.
- You will need to submit claim form to Delta. Delta will reimburse **you** for the services, NOT the Dentist.
- Your Dentist may require you to pay the **total** charges on the day services are performed.

HOW TO FILE A CLAIM
You do not have to fill out a claim when using an In-Network DPO Dentist or a DeltaPremier Participating Dentist. If you use a Non-Participating Dentist who chooses not to submit a claim to Delta, you will have to file your own claim. A claim form is included with your enrollment materials. Send the claim to the address on the claim form. Additional claim forms may be obtained by visiting the Employee Benefits website at www.state.co.us/benefits and clicking on "dental," then select "claim form" at the bottom of the drop-down menu. You may also call Delta's toll-free customer service number listed on the back page of this booklet.

Note: Claims are expected to be filed in a timely manner. Delta will not be obligated to pay claims submitted more than twelve (12) months (365 calendar days) after the date the service was provided.

WHEN YOU FILE A CLAIM (only required if you choose a Non-Participating Dentist)
- **You must** submit a separate claim form for each Dentist that provided Covered Services.
- **You must** also submit a separate claim form for each Covered Person when you are submitting charges for more than one covered family member.
- Make copies of the Dentist's bills for your own records.
- Complete your portion of the form and ask the Dentist to complete the remaining information. If the office will not complete the form, ask them to provide you with an original itemized bill that contains all the necessary information for processing your claim. Balance due statements, cash register receipts and canceled checks are not acceptable.
- Make sure the information on the claim form and the statement is complete and readable, otherwise it might cause a delay in payment.

PREAUTHORIZATION
Preauthorization is recommended when your Dentist's suggested treatment plan exceeds $400.00. Your Dentist may submit the treatment plan to Delta for review before any work is actually done. Preauthorization of benefits allows both you and your Dentist to know exactly what is covered and what your Plan will pay. There is no additional charge to have a Preauthorization done. Under most circumstances, Preauthorization constitutes an estimate for payment when the exact services are provided within sixty (60) days of a signed Preauthorization date, subject to any prior payment or benefit maximum reached.

Preauthorization is recommended for the following procedures:

- special restorations;
- removable prosthodontics;
- fixed prosthodontics;
- endodontics;
- oral surgery (except emergency procedures);
- periodontal treatment; and
- orthodontic treatment plans.

COVERED DENTAL SERVICES

CALENDAR YEAR BENEFIT MAXIMUM
Each eligible employee and each eligible dependent may receive up to $850.00 of covered dental benefits in each calendar year for Diagnostic, Preventive, Basic and Major Services.

CALENDAR YEAR DEDUCTIBLE
Each eligible employee and each eligible dependent is responsible for the first $50.00 each calendar year; Diagnostic and Preventive Services are not subject to the deductible.

LIFETIME ORTHODONTIC BENEFIT MAXIMUM
Benefit not available.

COINSURANCE PERCENTAGES

Covered Services	(DPO) Dentist In-Network	Participating Dentist Out-of-Network	Non-Participating Dentist Out-of-Network
*Class I: Preventive, Diagnostic and Adjunctive Services	100% of DPO Discounted Fee	100% of DPO Discounted Fee. You pay difference between Delta's payment & dentist's UC fee.	100% of DPO Discounted Fee. You pay difference between Delta's payment & dentist's full billed charges.
*Class II: Basic Services	50% of DPO Discounted Fee	50% of DPO Discounted Fee. You pay difference between Delta's payment & dentist's UC fee.	50% of DPO Discounted Fee. You pay difference between Delta's payment & dentist's full billed charges.
*Class III:Major Services	50% of DPO Discounted Fee	50% of DPO Discounted Fee. You pay difference between Delta's payment & dentist's UC fee.	50% of DPO Discounted Fee. You pay difference between Delta's payment & dentist's full billed charges.
*Class IV: Orthodontic Services	Benefit not available.	Benefit not available.	Benefit not available.

***Costs will vary depending upon which dental providers are utilized.**

BENEFITS

This Certificate of Coverage (hereinafter referred as the "Certificate") is part of the legal agreement between you (a Member) and us (Delta Dental Plan of Colorado, hereinafter referred as "Delta"). As a Member, you are bound by all of the terms of this Certificate. In exchange for your premium payment, we agree to pay for all or part of Covered Services as described in this Certificate. Our provision of benefits to you is conditional on timely receipt of premiums.

The legal agreement between you and us includes the following documents:

- This Certificate and any revisions made to it.
- Your Enrollment/Change Form.
- The Master Contract between us and your employer.

The above documents contain all the terms of the legal agreement between you and Delta, and supersede all other statements and contracts, oral or in writing, with respect to the subject matter of this Certificate. No change or modification or waiver of any of the provision of your agreement with us will be valid unless it is in writing, approved and signed by an authorized representative of Delta. Any such change or modification shall have been either requested in writing or signed by the employer. Further, no course of action, usage or custom or internal policy of Delta may amend or become part of our agreement with you.

I. DIAGNOSTIC, PREVENTIVE AND ADJUNCTIVE SERVICES

Diagnostic - Provides the necessary procedures to assist the dentist in evaluating the conditions existing and the dental care required. Covered Diagnostic Services include:

Oral Examination - to include initial, periodic or emergency

Dental X-Rays - to include complete (full mouth) series, single x-rays, or bitewings

Preventive - Provides the necessary procedures or techniques to prevent the occurrence of dental abnormalities or disease. Covered Preventive Services include:

Dental Cleaning - to include removal of all deposits and/or stains, and polishing as a single complete service

Adjunctive - Services including Emergency Services treatment performed as a temporary measure to relieve pain.

LIMITATIONS ON DIAGNOSTIC, PREVENTIVE AND ADJUNCTIVE BENEFITS

a. Cleanings (adult and child) and oral examinations are a benefit only twice in a calendar year period, unless special need exists. For payment purposes, an adult cleaning is not a benefit for persons under age fourteen (14).
b. Topical fluoride application is a benefit only to children to age fifteen (15), and is a benefit only twice in a calendar year period.
c. Complete mouth x-rays are a benefit only once in a thirty-six (36) month period, unless special need exists.
d. Bitewing x-rays are a benefit only twice in a calendar year period and are not a benefit in addition to a complete series.

LIMITATIONS ON DIAGNOSTIC, PREVENTIVE AND ADJUNCTIVE BENEFITS (Cont.)

e. Benefit for examination will not be made when performed in conjunction with any covered Adjunctive Service.
f. Benefit for covered diagnostic services may be made toward the cost of special diagnostic services or techniques and the patient shall be responsible for the portion of the dentist's fee in excess of the Delta allowance.
g. Space maintainer is a benefit only for premature loss of deciduous (baby) teeth for children to age nineteen (19).
h. Sealant Benefits include the application of sealants only to permanent molar teeth with the occlusal surfaces intact, no caries (decay), and with no restorations.
i. Separate benefit shall not be made for any preparation or conditioning of the tooth or any other procedure associated with sealant application.
j. Sealant Benefits do not include any repair or replacement of a sealant on any tooth within thirty-six (36) months of its application. Such repair or replacement is considered included in the fee for the initial placement of the sealant.
k. Sealants are a benefit only for eligible dependent children to age fifteen (15).

II. BASIC SERVICES

Restorative - Provides the necessary procedures to restore the teeth other than special restorative. Covered Basic Restorative Services include Amalgam, Silicate and Resin Restorations.

LIMITATIONS ON BASIC RESTORATIVE BENEFITS

a. Benefits for the same covered basic restorative service shall not be provided more than once in any twelve (12) month period.
b. Allowance for amalgam on posterior (back) teeth or intraorally cured (placed and hardened completely in the mouth) resin or plastic restorations (fillings) on anterior (front) teeth may be made toward the cost of more expensive procedures or materials selected, and the patient shall be responsible for the portion of the dentist's fee in excess of the Delta allowance.

Endodontics - Includes the necessary procedures for pulpal and root canal therapy.

Oral Surgery - Extractions, includes wisdom teeth and certain other surgical services including pre- and post-operative care and associated covered anesthesia.

Periodontics - Services for periodontal cleaning, surgical and non-surgical treatment of gums and bone supporting teeth.

LIMITATIONS ON ENDODONTIC AND PERIODONTIC SERVICES

a. Covered surgical periodontic services are a benefit only once in a three (3) year period and covered adjunctive periodontic services are a benefit only once in a two (2) year period, unless evidence of special need is provided to Delta.
b. Pulpotomy, Pulpectomy is a benefit only for deciduous (baby) teeth.

III. MAJOR SERVICES

Special Restorative - Crowns, jackets, cast, fused or other laboratory processed restorations, including gold restorations for teeth which cannot be restored with amalgam on posterior teeth or resin/plastic on anterior teeth.

LIMITATIONS ON SPECIAL RESTORATIVE BENEFITS

a. If more than one restoration is used to restore a tooth, benefit will not exceed the covered amount for a single covered service.
b. Special restorative services are a benefit only once in a five (5) year period for procedures involving the same teeth.
c. Special restorative services are not a benefit for children under age twelve (12).

Prosthodontics and Prosthodontic Maintenance - Services for construction or repair of fixed bridges, removable partial and complete dentures to replace completely extracted or missing natural permanent teeth. Additional services for rebase or reline of dentures, recementation of crowns, inlays or onlays.

LIMITATIONS ON PROSTHODONTIC BENEFITS

a. Replacement of an existing prosthetic appliance is a benefit once in five (5) years and only if the appliance is unsatisfactory and cannot be made satisfactory.
b. A covered prosthodontic appliance is a benefit only after five (5) years has elapsed for any payment of covered special restorative benefit for the same tooth.
c. Delta will pay the allowed percentage of the dentist's fee for a standard cast base metal and/or acrylic partial denture or a standard complete denture, up to a maximum fee allowance for a standard denture. The patient is responsible for the portion of the dentist's fee in excess of this allowance for any denture and/or related service.
d. Removable temporary partial dentures are a benefit only when anterior teeth are missing. An allowance limited to the covered amount for a removable appliance may be made toward the cost of the other procedures performed. The patient is responsible for the portion of the dentist's fee in excess of the Delta allowance.
e. Benefit based on the cost of a covered complete or removable partial denture may be made toward the cost of implants and appliances constructed in association therewith. If benefit is made for such an appliance, benefit will not be made for any replacement within five (5) years thereafter.
f. Benefit for reline or rebase of a prosthodontic appliance will be made only once in any three (3) year period.
g. Fixed bridges and/or cast metal framework partial dentures are not a benefit for persons under age sixteen (16).

GENERAL LIMITATIONS - ALL SERVICES

a. If an eligible person selects a service that is not a benefit or selects a specialized technique instead of a standard service, Delta will pay the applicable percentage of the fee for the least costly commonly performed covered service and the patient is responsible for the remainder of the dentist's fee.
b. Services involving veneers, facings, or any other cosmetic services posterior to the first molar are considered optional and are not a benefit. An allowance may be made for the covered amount of the covered service without veneers, facings or cosmetic components. The patient is responsible for the portion of the dentist's fee in excess of the Delta allowance.
c. Pre- and post-operative procedures are considered part of any covered service and are not benefits. Benefit shall be limited to the covered amount for the covered service.

d. Local anesthesia is considered a component of any procedure in which it is used.
e. Allowance for covered service started but not completed shall be limited to the amount determined by Delta.
f. A temporary dental service will be considered an integral part of a complete dental service rather than a separate service, and separate payment shall not be made for a temporary service unless otherwise included as a covered service.
g. Allowance for an assistant surgeon when determined by Delta to be a covered benefit shall not exceed 20% of the surgeon's fee for the same covered service.

EXCLUSIONS

THE FOLLOWING SERVICES ARE NOT BENEFITS:

a. Services for injuries or conditions which are compensable under Worker's Compensation or employer's liability laws, or services which are provided to the eligible person by any federal or state government agency or are provided without cost to the eligible person by any municipality, county or other political sub-division, or any services for which the eligible person would have no obligation to pay in absence of this coverage, except as such exclusion may be prohibited by law.
b. Any covered service started during any period when the person was not eligible for such service.
c. Services for treatment of congenital (present at birth) or developmental (following birth) malformations, except intraoral dental services for treatment of a condition which is related to or developed as a result of cleft lip and/or cleft palate, unless otherwise included as a covered service.
d. Services for cosmetic reasons.
e. Services for restoring tooth structure lost from wear or for any services related to protecting, altering, correcting, stabilizing, rebuilding or maintaining teeth due to improper alignment, occlusion or contour or for splinting or stabilization of teeth.
f. Habit appliances, and gnathological (jaw function) services, bite registration or analysis, or any related services.
g. Pre-medication, analgesia, hypnosis or any other patient management services.
h. Charges for prescription drugs.
i. Experimental procedures, or any procedures other than those covered services for which the prognosis is good (as defined by Delta). Any procedures done in anticipation of future need (except covered preventive services).
j. Hospital costs and any additional fees charged by the dentist or hospital for hospital services, visits, or charges for use of any facility.
k. Anesthesia other than general anesthesia, intravenous sedation or analgesia administered in connection with covered oral surgery services as provided for in the Contract.
l. Extraoral grafts (grafting of tissues or other substances from outside the mouth to or into oral tissues), augmentations or implants and/or any associated appliances. Removal of implants or any services associated therewith.
m. Orthodontic services including any related diagnostic, preventive or interceptive services (surgical and other treatment of malalignment of teeth and/or jaws). Myofunctional therapy or speech therapy.
n. Services for the treatment of any disturbances of the temporomandibular joint (jaw joint), facial pain, or any related conditions, including any related diagnostic, preventive or interceptive services.
o. Services not performed in accordance with the laws of the state of Colorado, services performed by any person other than a person authorized by license to perform such services, or services performed to treat any condition, other than an oral or dental disease, malformation, abnormality or condition.
p. Oral hygiene instructions or dietary instructions.

q. Completion of forms, providing diagnostic information or records, or duplication of x-rays or other records.
r. Replacement of lost, stolen or damaged appliances.
s. Any services not specifically included as covered.
t. Services for which payment is prohibited by any law of the jurisdiction in which the eligible person resides at the time the expenses are incurred.
u. Services for which charges would not have been made if this coverage had not existed, except for services as provided under Medicaid.

COORDINATION OF BENEFITS

1. If a covered person is entitled to coverage under two or more plans, then the benefits of this plan shall be coordinated with other plan benefits.

   - Plan means any plan providing dental care benefits under group, blanket or franchise coverage; or service type plans or other group pre-paid plans; or coverage under any governmental plan or required by law; or "No-Fault" motor vehicle insurance.
   - Primary coverage is the coverage that has the first responsibility for paying a claim. The primary coverage must pay up to its full liability.
   - Secondary coverage is the coverage (or coverages) responsible for paying a claim after the primary coverage has paid up to its full liability.

2. Order of benefit determination if the other coverage is by a dental insurance policy or prepaid dental care program:
   a. The policy or program covering the patient as an employee shall be primary over the policy or program covering the patient as a dependent;

   b. For dependent children's expenses the order of benefit determination shall be as follows:
      i. The policy of the parent whose birthday (excluding year of birth) occurs earlier in a year shall be primary, or;
      ii. If the parents are separated or divorced, the policy of the parent who is ordered by court decree to take financial responsibility for dental expenses shall be primary, or;
      iii. The policy of the parent with custody is primary and if said parent has remarried, the step-parent's plan is secondary and the plan of the parent without custody pays third.

   c. If the above rules do not establish an order of benefit determination, the plan that has covered the person for the longer period of time shall be primary with the following exception:

      The plan covering the person as a laid-off or retired employee or dependent of such person, shall be determined after the benefits of any other plan covering the person or employee.

   d. Any group plan that does not contain a coordination of benefits provision is automatically primary.

If this Plan is primary as provided above, this Plan shall provide benefits without regard to benefits provided by any other Plan. If this Plan is secondary, this Plan will pay the same benefits that it would have paid (had it paid first), **less** whatever payments were actually made by the Plan (or Plans) that paid first. In addition, when this Plan pays second, it will never pay more in benefits than it would have paid for each claim, as it is submitted, had it been the Plan that paid first. As a result, when this Plan pays second, you may not receive the equivalent of 100% of the total cost of the Covered Services.

DENTAL HEALTH INFORMATION DISCLOSURE

The Administering Company cannot release your dental information without your written consent. That information is strictly confidential. However, there are some exceptions:

- information that is requested for utilization summaries or reviews given to your Employer, since your Employer funds all or part of the cost of your claims
- peer and utilization review boards and the Administering Company's dental consultants need the information to ensure that you are getting the necessary Covered Services for dental
- there is a judicial or administrative subpoena for the information
- the Colorado Division of Insurance requests the information
- the information is required for:
    - Worker's Compensation proceedings
    - No-Fault auto insurance cases
    - third-party liability (subrogation) proceedings
    - coordination of benefits

Except as required by applicable law, the Administering Company cannot release to you any information that a Dentist gave to the Administering Company, unless it has the Dentist's written consent.

EXTENDED COVERAGE
(Extension of Benefits)

If eligibility is terminated, Delta will pay for services that were Preauthorized and started prior to the date of termination. The extended coverage will not exceed sixty (60) days and applies only to single covered services that are fixed or removable prosthodontic appliances, crowns, jackets, cast, fused or other laboratory processed restorations and were installed or seated within sixty (60) days after termination of coverage.

INTERNAL APPEAL OF CLAIMS

Delta Dental Plan of Colorado uses those procedures outlined in Colorado Division of Insurance Regulation 4-2-17 for investigating denied claims involving utilization review. Utilization review means a set of formal techniques designed to monitor the use of, or evaluate the medical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings.

Questions concerning the action taken on a claim can be directed to the Customer Service Department for clarification. If the explanation is not acceptable, you may appeal the determination by writing to the Dental Director of Delta Dental within one hundred and eighty (180) days after receiving a written denial. Delta may submit the matter to the Executive Committee of the Board of Trustees for review. Any written communication should include documents or records in support of your claim.

Send your appeal request to:

Dental Director
Delta Dental Plan of Colorado
P.O. Box 5468
Denver, CO 80217-5468

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EXTERNAL APPEAL OF CLAIMS
(only available on qualified claims)

In addition to the Internal Appeal procedures, covered persons have certain rights under Colorado Division of Insurance Regulation 4-2-21. You may request an Independent External Review of a claim if the above Internal Appeal procedures result in a final denial **AND** the final denial is based on one of the following reasons:

- medical necessity;
- effectiveness;
- efficiency;
- experimental; or
- investigational.

When a claim qualifies for External Review, Delta will mail you a notice that explains your right to request an Independent External Review of the denied claim. In addition to the notice, you will receive the required form for submitting your request. You need to complete the form and mail it to the address listed on the bottom of the form.

PAYMENTS MADE IN ERROR

Should the Plan make a payment in error, the Plan has the right to recover the payment from the Covered Person or Dentist. If the Plan recovers payment from the Dentist, the Dentist may have the right to recover payment from you. The Plan can also recover incorrect payment amounts by paying less on future claims and/or taking legal action.

If the Plan is required to take any legal action to uphold its rights and it prevails, you are required to pay the Plan's legal expenses and your own, including attorney fees and court costs.

COBRA CONTINUATION COVERAGE

You and your eligible dependents who were enrolled when coverage ended under your employer sponsored group health plan (which includes dental plan coverage) may be entitled to elect continued coverage at your own expense if coverage is lost due to certain "Qualifying Events."

Eligible employees and dependents losing coverage due to either of the following Qualifying Events may elect to continue coverage for up to eighteen (18) months from the date in which the event occurs:

- termination of employment; or
- reduction of hours

Any eligible employee or dependent who is eligible for COBRA continuation coverage who is disabled and determined to be eligible for Social Security disability benefits at the time of termination of employment or reduction of hours may elect to extend coverage for themselves and their dependents for up to an additional eleven (11) months following the eighteen (18) month extension allowed for the initial Qualifying Event. This right also applies if the eligible employee or dependent is totally and permanently disabled within sixty (60) days after termination of employment or reduction of hours. The employee or dependent must notify the employer in writing of the Social Security, State disability carrier decision, or PERA decision regarding disability determination within thirty (30) days of the date it is issued, and before the end of the initial eighteen (18) month COBRA coverage period. The employee or dependent must also notify the employer within thirty (30) days of the date of any final determination by the Social Security Administration that the employee or dependent is no longer disabled.

Eligible dependents losing coverage due to any of the following Qualifying Events may elect to continue coverage for up to thirty-six (36) months:

- death of a covered employee
- divorce or legal separation of the covered employee
- qualification of the covered employee for Medicare benefits; or
- disqualification of child as a dependent

Anyone who has elected continued coverage and becomes covered under another plan may continue coverage if the plan contains a pre-existing condition limitation. Coverage will be continued until the earlier of: the expiration of the pre-existing condition limitation of the new plan or the expiration of the original continuation period. The new plan must count the months for which you have had prior creditable coverage for the pre-existing condition. It is the employee's or dependent's responsibility to consult with their new plan administrator to determine if this provision applies in their case.

If a COBRA enrollee becomes entitled to Medicare before the expiration of eighteen (18) months then any of his dependents will be entitled to continuation of coverage for a total of thirty-six (36) months from the date of the original Qualifying Event.

Anyone who is entitled to elect continued coverage based on more than one Qualifying Event shall be limited to continued coverage for a total of thirty-six (36) months following the date of the first Qualifying Event.

You or your dependent must notify your employer within thirty (30) days after a divorce or legal separation, or if a dependent child loses eligibility. Otherwise, the option of continued coverage based on one of these events will be lost.

Once aware of a Qualifying Event, the employer will notify affected persons about their right to elect continued coverage. This notice will include the amount of monthly fees the employer will charge them for continued coverage as permitted by law. Persons desiring continued coverage must advise the employer within sixty (60) days after receiving such notice, or within sixty (60) days after losing coverage due to the Qualifying Event, whichever is later. You or your dependent will then have forty-five (45) days to pay the initial installment of fees which shall include fees for all months since the Qualifying Event.

Continued coverage shall be the same as for eligible employees and their dependents. If coverage is modified for eligible employees and their dependents, it shall also be modified in the same manner for persons with continued coverage and an appropriate adjustment in fees may be made by the employer.

After COBRA coverage begins, the COBRA enrollee may add a newborn child, an adopted child or a child who has been placed with the employee for adoption and for whom the employee has financial responsibility. The COBRA enrollee must notify the employer in writing within thirty-one (31) days of the birth or placement in order to add the child to the COBRA coverage. A child born, adopted or placed for adoption and enrolled as indicated will have the same COBRA rights as any other dependents covered by the plan before the event that triggered COBRA coverage.

Continuation coverage under federal law may terminate earlier than the periods stated above. Coverage will terminate at the end of the month in which any of the following events first occurs:

1. The employer no longer provides any group dental plan to any employee.
2. Fees and/or premiums are not paid for the person as required.
3. The covered person becomes enrolled for dental benefits under another group dental plan (as an employee or otherwise) that does not limit or exclude coverage for a pre-existing dental condition that they may have.
4. The covered person becomes entitled to Medicare.
5. The allowable number of months of continued coverage (i.e. 18, 29 or 36 months) expires.
6. A covered person whose coverage was extended to 29 months because of disability is no longer considered disabled under the Social Security Act.
7. There is any reason that would end coverage for an Employee in a similar situation.

Once continued coverage for COBRA terminates, it cannot be reinstated.

DENTAL TERMINOLOGY

Amalgam: A mixture of two or more metals in combination with mercury used as a restorative material.

Anesthesia: The loss of sensation or feeling with or without loss of consciousness.

Anterior: Front. The first six teeth in the upper and lower jaw.

Bitewing: X-ray film; generally diagnostic to detect the presence of dental decay.

Bridge: (Fixed) An appliance replacing missing or extracted natural teeth, supported and held by attachments to restored (abutment) teeth and usually not removable.

Cast: Reproduction of the form of all or part of the dental arch (teeth and tissues) made from plaster or stone.

Crown: The portion of a human tooth covered by enamel. A dental prostheses restoring the function and esthetics of part or whole of the coronal portion of the natural tooth; usually composed of gold, porcelain, or acrylic resin.

Denture: An artificial substitute for missing natural teeth, either being complete (full) or partial.

Denture Reline: To resurface the tissue-borne areas of a denture with a new material.

Endodontics: A specialty area of dentistry concerned with diagnosis and treatment of diseases of the pulp chamber and canals.

Extraction: The separation and surgical removal of a tooth from its natural state.

Fluoride Treatment: A topical application of a solution of a fluoride to the teeth to protect against decay.

Impacted Tooth: Condition in which the unerupted or partially erupted tooth is positioned against another tooth, bone or soft tissue, thereby preventing complete eruption of the tooth.

Implantation: An insert into bone to support a crown or crowns, a partial denture or complete denture.

Inlay: A filling made outside a tooth, inserted in one piece and retained by aid of cement.

Oral Hygiene Instruction: Instruction on proper care of teeth.

Palliative: Action that relieves pain but is not curative.

Panorex: X-ray film that shows the curve of each dental arch and all the teeth therein; full mouth x-ray.

Partial Denture: An artificial device which replaces one or more but less than all of the natural teeth and associated structures that are supported by the teeth, being either removable or fixed.

Periodontics: The study and treatment of the gingival tissues; the tissues supporting the teeth.

Prophylaxis: A procedure of removing plaque, calculus and stains from tooth surfaces by scaling and polishing techniques; Cleaning.

Rebase: A process of refitting a denture by replacement of the denture base material.

Reline: To resurface the tissue side of a denture with new base material to make it fit more accurately.

Resin: Organic substances that may be solid or semi-solid in form. Resins are used as a filling material and are named according to their chemical composition, physical structure and means of activation or curing.

Restoration: The term applied to the end result of repairing and restoring or reforming the shape, form, and function of part or all of a tooth.

Root Canal Therapy: Treatment of a tooth having a damaged pulp, usually performed by completely removing the pulp, sterilizing the pulp chamber and root canals, and filling these spaces with insert sealing material.

Sealants: Protective covering applied to the occlusal surfaces of permanent bicuspids and molars to prevent decay in children's teeth.

Space Maintainer: A fixed or removable appliance designed to preserve the space created by the premature loss of a tooth.

Temporomandibular Joint: The connecting hinge mechanism between the mandible (lower jaw) and the base of the skull (temporal bone).

Veneer: A layer of tooth colored material, usually porcelain or acrylic resin, that is attached to the surface of a crown or pontic by direct fusion, cementation, or mechanical retention.

Delta Dental Plan of Colorado

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1/03